



**Integrated Care  
Systems Network**  
NHS Confederation

# The state of integrated care systems 2022/23

Riding the storm

# About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.

Integration and partnership working are the driving force of healthcare. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

This is our central focus. We support integration across our membership, connecting different parts of the health and care system to share learning and develop solutions to shared challenges.

The members we represent employ over 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure.

The Integrated Care Systems (ICS) Network is the only independent national network which supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda. We are delighted to have all 42 ICSs in membership.

We support, represent and influence on our members' behalf

through our policy work, media appearances and external affairs programme.

# Key points

- As integrated care systems (ICSs) mark the first anniversary as formal partnerships, this report examines the progress that local systems have made, opportunities for further development and the areas where ICSs require action and commitment from national partners in order to ensure that they are able to effectively deliver for the population that they serve.
- The report shows that ICSs have got off to a strong start in a difficult operating environment – one that has been marked by one of the most challenging winters on record, rising demand for care, a cost-of-living crisis, ongoing industrial action, and reductions in the running costs of ICBs that materialised just seven months into their existence as statutory bodies.
- Nine in ten ICS leaders say that partners within their local systems are working collaboratively to set and deliver on their key priorities. Nine in ten ICS leaders also report that their ICB and ICP are working well together. ICS leaders do, however, highlight some of the challenges of partnership working and will look to build on this progress by strengthening collaboration and building capacity across all system partners.
- ICS leaders and their partner organisations are positive about the progress that local systems have made. These include coordinating the operational response to winter pressures, encompassing urgent and emergency care, discharge and elective recovery; developing and strengthening place-based arrangements and cross-system collaboratives; supporting and commissioning primary care; improving financial sustainability and productivity; enhancing engagement and co-production capabilities; and developing long-term, joint strategic plans.
- However, ICS leaders report a number of barriers that are impeding their progress and which require action from government and national bodies. The top three are: staff shortages and the lack of an equivalent long-term workforce plan for social care; a lack of funding for social care; and NHS

finances, including unexpected cuts to ICB running costs and an ineffective capital regime.

- At the same time, ICBs have taken on greater responsibilities than when they went 'live', including the commissioning of primary pharmacy, optometry and dentistry services, and they have now been charged with implementing large elements of the NHS Long Term Workforce Plan. There is a clear danger that they are being asked to take on too much while their running costs are reduced by 30 per cent. In particular, the further delegation of functions requires specialist capability which will now be in shorter supply.
- These barriers are compounded by a short-termist approach within government that is dragging ICSs into more immediate operational priorities over the long-term shift towards integration, equity and prevention that they have been tasked with delivering.
- While ICS leaders identify a number of areas where progress has been made, they also pinpoint areas where progress has been slower than hoped. These include their plans and commitment to supporting greater devolution. There are positive examples of devolved decision-making and provider collaboratives that ICSs will want to build on, but as place-based partnerships and provider collaboratives mature, ICS leaders recognise the need to devolve more decisions and functions to a more local level. That is their intention in the next period of their development.
- On behalf of ICS leaders, and to best support ICSs in year two of their existence as formal partnerships, this report makes a number of recommendations to policymakers in government and national bodies:
- 1. Social care workforce plan:

We welcome the NHS Long Term Workforce Plan and call on the government to demonstrate its commitment to supporting the social care sector by developing an equivalent plan for the social care workforce.

- 2. Capital spending review:

We support the government's commitment to reviewing the entire NHS capital regime in response to the Hewitt review. We call on the government to include in this review the amount of capital funding as well as the complex allocation process, which is resulting in delays in accessing funding that could be used to enhance productivity.

- 3. New commissioning functions:

NHS England (NHSE) should work closely with ICBs to ensure that they have access to the data and the capacity they need to effectively discharge their new commissioning functions and responsibilities.

- 4. Devolve to evolve:

We encourage the government and NHSE to commit to their intention to set a small number of core targets based on outcomes and to give ICSs the autonomy to innovate in how they deliver against these targets.

- 5. Co-production:

We support a shift whereby co-production of national policy and guidance with ICSs becomes the norm, reflecting the planned changes to NHS England's operating model. This should help to ensure that the support provided through NHSE's regional and national teams is aligned with what ICSs need.

# Introduction

Integrated care systems were born into a challenging context. Since their formal establishment in July 2022, including the creation of ICBs as statutory bodies, they have weathered political and economic uncertainty, rising inflation and a cost-of-living crisis. The health and care system faced one of its toughest winters yet, with immense pressure on emergency services, an uphill battle to tackle the elective care backlog and the huge financial and workforce challenges facing the NHS and social care.

The State of Integrated Care Systems is the ICS Network's flagship annual report series, reflecting the views of ICS leaders on the development and impact of ICSs.

Through this report, we aim to provide insights into the successes and challenges of ICSs one year after their formal establishment. Building on the Hewitt review and through engagement with our members, we have identified key recommendations that we believe will give ICSs the conditions they need to deliver for the local population that they serve. See Annex 2 for a summary of the recommendations ICS leaders see as the highest priority.

The research is primarily based on a national survey of ICS leaders (ICB chairs and CEOs and ICP chairs), which was followed up with a number of interviews. We also held roundtables and interviews with wider system partners to provide additional context and insight and, worked with Carnall Farrar to add some quantitative performance insights. We intend to use this report to shape our influencing strategy over the coming year and will continue to work with partners to implement the recommendations and to build on our approach for future reports. We would like to extend thanks on behalf of the ICS Network to

everyone who participated, for their incredibly helpful insights and contributions.

## A note on language

An integrated care system (ICS) is the system that brings together the health and care organisations in a particular local area to deliver joined-up health and care services. Each ICS is responsible for planning health and care services in the area it covers. There are 42 ICSs across England. Each one is made up of an integrated care board (ICB) and an integrated care partnership (ICP), which will work in tandem to meet their four purposes:

1. Improving population health and healthcare outcomes.
2. Enhancing productivity and value for money.
3. Tackling inequalities in outcomes, experience and access.
4. Helping the NHS to support broader social and economic development.

ICBs are statutory NHS organisations responsible for developing a joint forward plan in collaboration with NHS trusts / foundation trusts and other system partners for meeting the health needs of their population, managing the NHS budget and arranging for the provision of health services in their defined area.

The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population. It operates as a statutory committee formed between the NHS ICB and all upper-tier local authorities that fall within the area, with membership of other partner organisations determined locally.

We refer to ICB and ICP leaders collectively as 'ICS leaders' and to all the bodies working together within the ICS geography as 'system partners' or 'the system' when talking about the entire range of activity that the ICS is working towards. At other times,



we refer to the views of ICB and ICS leaders when we are writing more specifically about those entities.

## Methodology

The report is based on data collected through quantitative, qualitative and desk research.

We invited leaders of the 42 ICSs in England to share their views on ICS development through a national survey, which was open to chief executives and chairs of ICBs and chairs of ICPs. The survey ran from 14 March to 25 April 2023. We received 47 responses overall, representing 36 out of 42 systems: over 85 per cent of systems.

Responses were split across 19 ICB chairs, 16 ICB chief executives, six ICP chairs and seven joint ICB/ICP chairs. Some of the questions were asked specifically to certain respondents, such as ICB and ICP chairs. At times we have compared responses to last year's survey, but comparison is limited by different wording of questions and the individuals completing the survey. As this is the first year of formal ICS partnerships, we intend to use this year's survey as a baseline for ICS progress going forward.

In order to complement and test our survey findings, we ran five roundtables throughout April and May 2023, with key stakeholders from across community and mental health, acute and ambulance providers, primary care and place leaders, voluntary, community and social enterprise (VCSE) partners and local government. We also undertook individual interviews with seven survey respondents to explore their answers in greater depth.

In conjunction with our partners Carnall Farrar, we have also looked at the relationship between our survey responses and related performance measures within Carnall Farrar's Insights and Collaboration Engine (ICE). Annex 1 has a full explanation of the ICE tool and a description of the analysis conducted by Carnall Farrar.

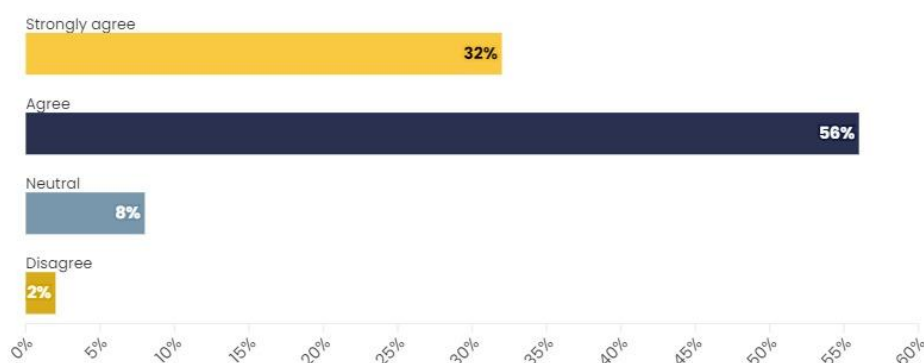
# Progress to date

In their first year as formal partnerships, ICSs have delivered impact in a challenging operating context. Progress looks different across different systems, places and neighbourhoods depending on local dynamics, geographies, levels of maturity and the specific needs of local populations.

## Building relationships

Nearly nine in ten leaders responding to our survey feel that partners within their ICSs (including NHS trusts, primary care, VCSE, local government social care providers) are working collaboratively to both set and deliver on priorities.

**“In general, partners within my ICS are working collaboratively to set and deliver on priorities.”**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
n=45

These findings are consistent with last year’s survey, suggesting that relationship building continues to be a key area of focus for ICSs. One ICB CEO described their relationships as ‘very collegiate’ with a ‘strong system identity, supported by developing place and neighbourhood structures’. Responses also reinforce the time commitment that this requires, with one ICB chair

describing the ‘major time and energy’ taken to ‘get to a good place’.

Relationships have developed differently due to local dynamics and arrangements, history and maturity. As one ICB CEO remarked: “We have a very strong set of relationships at all levels, forged over the last seven years as an STP/ICS. This takes constant attention.” A community trust leader similarly described the productive approach to problem solving in their more mature system, where problems are seen not as a barrier but an opportunity to work together. NHS Providers’ [regulation report](#) found that NHS trust leaders were overwhelmingly positive about ICBs’ role in fostering a sense of shared responsibility and collective endeavour among system partners, bringing them together to solve problems and share practice on patient care and outcomes.

An area where ICSs are particularly positive about progress was the relationship between the ICB and ICP. Over nine in ten ICS leaders report that the ICB and ICP are working positively together. Building on the recent publication of integrated care strategies, ICPs now have the opportunity to further develop their role, bringing together the breadth of system partners including places and health and wellbeing boards to address the wider determinants of health. Different ICSs, however, have different plans for where to take the ICP in the context of their own local dynamics and place-based arrangements.

One joint ICB/ICP chair shared their ICS development plans, including making the ICP the more important body:

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“While the ICB should take care of the system and money, the ICP should be busy driving key objectives at place, in provider collaboratives and maintaining a future focus.”

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In order to support these discussions, the NHS Confederation's ICS Network will be developing a report with the Local Government Association (LGA), setting out the different approaches being taken to the role and resourcing of the ICP by different systems.

## Delivering impact in the short and longer term

We asked ICS leaders where they feel they have delivered impact in the last year. Some of the examples provided included cross-system strategic planning; coordinating the operational response to winter pressures including urgent and emergency care, discharge and elective recovery; developing and strengthening place-based arrangements and cross-system collaboratives; supporting and commissioning primary care; financial sustainability and improving productivity; enhancing engagement and co-production capabilities and developing long-term joint strategic plans.

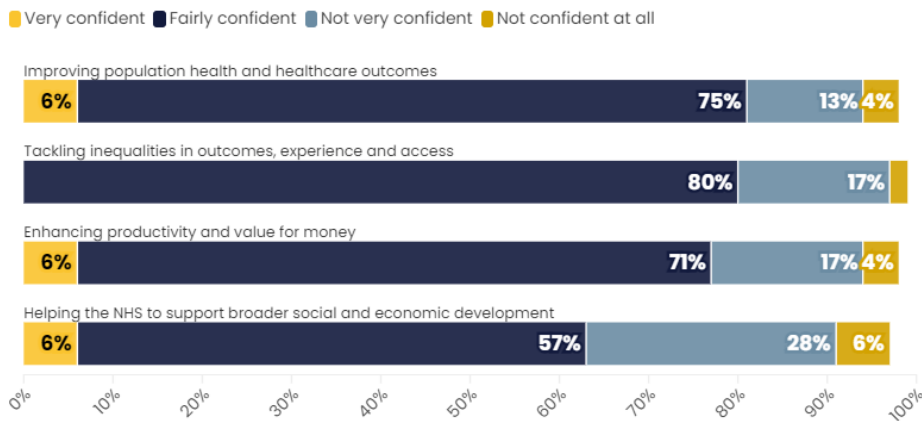
However, several respondents noted that some material benefits are difficult to quantify just nine months after ICSs' establishment as formal partnerships. ICS leaders also highlighted the issues created by a short-termist approach within government that prioritises short-term operational imperatives over long-term transformation – something which ICS leaders worry could increase in the run up to an election.

### Case study: Empowering patients and reducing pressure on urgent care services through the WaitLess app in Lincolnshire

Lincolnshire Integrated Care Board has launched an app, developed by VitalHubUK, called WaitLess. The app provides real-

time data on waiting times, queue numbers and travel time to urgent care facilities in the county, helping people choose the most appropriate urgent care services and understand waiting times better. The app has helped direct patients to alternative sites across Lincolnshire with lower waiting times so they can be treated more quickly, therefore improving patient experience and reducing pressure on urgent and emergency care services – something that was particularly valuable in such a large geographical county. [Find out more.](#)

**"How confident are you that your system is currently able to fulfil each of the following four purposes of an ICS?"**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
Sorted by most very confident/confident responses, n=45

Broadly, ICS leaders are positive about their system’s ability to fulfil their four statutory purposes. There is less confidence at this stage in relation to the role of the NHS in social and economic development, perhaps a less traditional NHS priority and the area most reliant on mature partnership working, where the ICP will have a significant role to play. The NHS Confederation is working with NAVCA, National Voices, and the LGA to capture and share learning about how the NHS can support social and economic development through its ICS partnerships.

Further analysis conducted in partnership with Carnall Farrar shows that there is an association between survey respondents’ confidence in improving population health and healthcare outcomes and those systems’ higher performance in several

population health and healthcare outcomes, suggesting that ICS leaders' self-perception was justified. Further detail on this analysis is provided in Annex 1.

# Areas for future improvement

ICS leaders are keen to build on progress and highlight two areas where they aim to focus their attention during the next period of development.

## Devolved decision-making

ICS leaders remain committed to devolution to place-based partnerships and provider collaboratives as they mature. For ICBs this will mean further delegation of responsibilities and decision-making powers. As one ICB CEO commented:

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“We have significant ambition and plans to delegate to areas such as place, provider collaboratives and PCNs.”

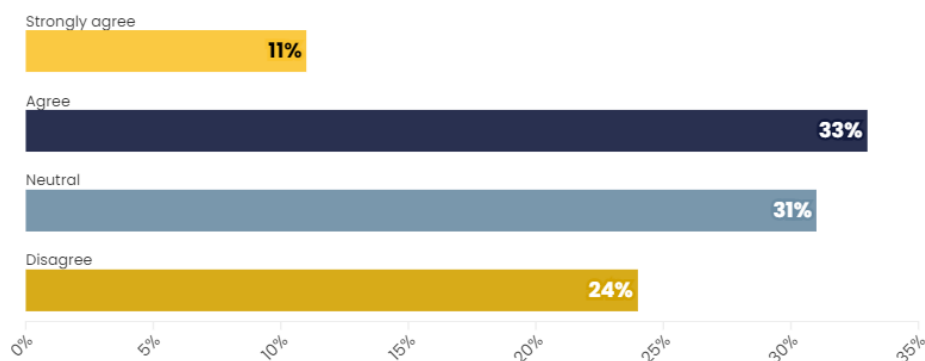
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This principle of subsidiarity is a core element of ICS development and is mirrored by work at a national and regional level to support greater devolution, for example through the Greater Manchester devolution deal. The NHS Confederation and LGA’s jointly-hosted Health and Devolution Working Group is supporting ICS and local government leaders to look at how the government can support health in devolution, informing practice and creating a space for an ongoing conversation.

However, despite this commitment and intention to devolve decision-making within ICSs, only 45 per cent of survey respondents felt that their ICS currently devolves decisions to the most local level, as close to local communities as possible. Some system partners we spoke to also reported slowed progress in

devolved decision-making and a lag between technical delegation and true subsidiarity.

**“My ICS devolves decisions to the most local level, as close to our local communities as possible.”**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
n=45

For many systems, the past year has been about establishing system governance and the core building blocks which can in turn enable smooth and effective delegation and devolved decision-making. ICBs understandably need assurance that place-based partnerships, provider collaboratives and other bodies have the requisite resourcing and maturity to take on additional functions. ICBs will want to learn from and build on positive examples of devolved decision-making.

Further analysis of our survey findings revealed an association between ICS leaders’ confidence in place-based partnerships. This was measured using an unweighted average of two questions on place-based partnerships, and performance of their ICS on population health management based on metrics from the ICE tool (see further details in Annex 1).

**Case study: Black Country Provider Collaborative works closely with the integrated care board and clinical networks to drive system-wide improvements**



The Black Country Provider Collaborative (BCPC) has progressed a diverse range of clinical, corporate and system transformation work through a range of clinical and functional networks across the Black Country ICB, to support delivery of the clinical strategy and joint forward plan.

Progress has been positive, with the establishment of clinical guidelines to better manage patient referrals; procurement of two surgical robots enabling better management of cancer service delivery through the concept of centres of excellence; the pursuit of elective care recovery through the 'Further Faster' 26-week national pilot, in parallel to focusing on fragile services through networked service solutions providing resilience for specialties across the system.

Collaborative working has also enabled the successful submission of business cases to secure additional community diagnostic centres, a new Mohs Surgery service, and the development of an orthopaedic elective cold site at Cannock Chase Hospital, with continued efforts to reduce variation in care across all sites through best practice such as GIRFT.

BCPC holds regular clinical summits, providing an opportunity for representatives from local trusts and other clinical leaders to come together with ICB leaders and wider stakeholders to support joint working and sharing of good practice.

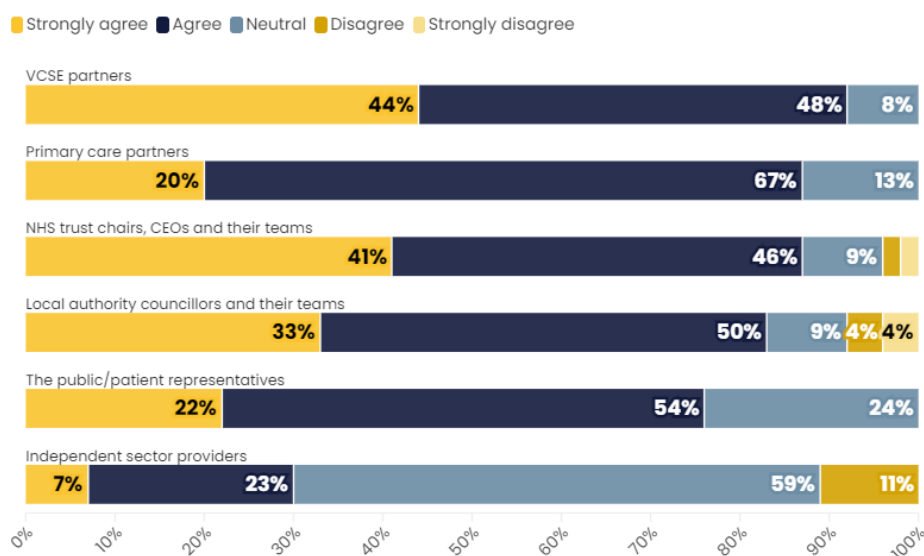
## Harnessing the skills and contributions of system partners

ICS leaders are exploring opportunities to further harness the unique skills and contributions of system partners. Overall, ICSs are positive about the commitment and contribution of system partners to the ICS, in particular in relation to the VCSE sector. ICS leaders also recognise the important role that primary care has to

play and acknowledge the capacity constraints that exist and potential role of ICSs in providing further support.

The findings are less positive in relation to the independent sector. When we discussed this further with an ICB CEO, they felt that engagement with the independent sector is variable and focused on supporting elective recovery and financial balance. They called for ‘a clearer ask so we can have a better conversation with the sector.’

**"To what extent would you agree or disagree that the following parties are supportive and actively contributing to the delivery of your ICS's ambitions?"**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
Sorted by most strongly agree/agree responses, n=46

While the picture on collaborative working is generally positive, ICS leaders recognise that different systems have different starting points when it comes to system-wide relationships. Dynamics such as levels of co-terminosity can also impact on joint working. One ICB CEO commented that for them it has been easier to build constructive relationships around tackling health inequalities than social care integration. One ICB chair highlighted some of the challenges they have had in shifting from an organising principle of competition to one of collaboration:

“Whilst progress is being made, there are still instances of individuals reverting to previous approaches and behaviours and prioritising organisations over the system – probably best described as some individuals looking to build a castle while the rest of us are looking to build a village.”

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These challenges of collaboration are also highlighted by system partners. Some local government and primary care leaders reported that while they feel able to engage within the ICS, this does not always feel like genuine collaboration, and both groups felt that acute providers still hold the strongest voice in the system. This mirrors the findings of the County Councils Network survey that there are significant challenges to overcome before councils can consider ICSs a truly partnership arrangement. This is perhaps unsurprising given that statutory ICSs and the ‘triple aim’ are only a year old. As the Hewitt review argued, sustained cultural change is required at all levels, including within providers, ICPs and ICBs.

ICS leaders acknowledge that there is further work to do to ensure that both the ICB and ICP are able to fully involve system partners and benefit from their expertise. This was recognised also by social care and VCSE partners who noted some opportunities to maximise their contribution to ICSs, for example working with systems to better support specific patient groups.

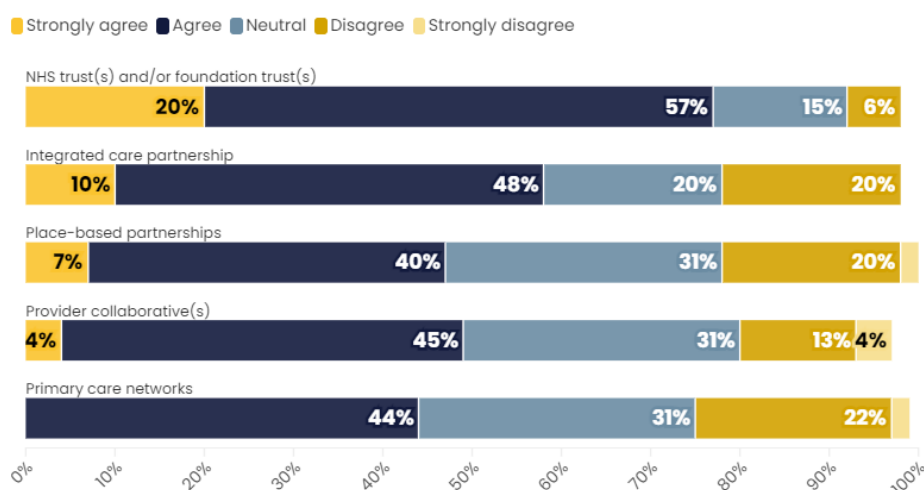
### Case study: Collaboration between West Yorkshire ICB and the local VCSE sector is supporting the NHS to become community powered

In West Yorkshire, the VCSE is a key and equal partner in achieving the ICSs’ ambitions and vision. The ICB and local VCSE sector

have a written memorandum of understanding (MOU) to deliver better health and wellbeing outcomes for the local population. The VCSE sector is a full voting member on the ICB board and on each of the place-based ICB committees. A programme, Harnessing the Power of Communities, underpins the collaboration by the ICB and local VCSE sector and supports a co-created approach to service decision and decision-making, as well as greater inclusivity and accessibility in commissioning and service provision. The ICB has also allocated significant funding to the VCSE and local hospices to support sector sustainability. [Find out more.](#)

West Yorkshire, Humber and North Yorkshire, and South Yorkshire ICBs, Yorkshire Sports Foundation and the two combined local authorities jointly commissioned some [research by Durham University](#) into the impact and contribution of the VCSE sector on health, personal, social and community wellbeing. The research found that the VCSE sector in the region produced over £10 billion in social and economic impact in 2022.

**"To what extent do you agree or disagree that each of the following have the requisite level of resourcing and maturity to deliver the ambitions outlined in your integrated care strategy?"**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
Sorted by most strongly/agree responses, n=45

Despite the strong support demonstrated through our survey, there is clear recognition of the resourcing and maturity

challenges that exist in various parts of the sector, particularly within primary care where 50 per cent of ICS leaders did not think primary care networks (PCNs) have the requisite level of resourcing and maturity to deliver the ambitions outlined in their integrated care strategy. These findings were supported by the primary care leaders we spoke to, who referenced the unrealistic expectations that can exist. Similarly, one ICB CEO's view was that there has been an over-expectation of what PCNs can deliver within their existing infrastructure and leadership capabilities, rather than being a vehicle for transforming primary care.

Both ICS and primary care leaders are clear that PCNs will need the autonomy and support infrastructure to allow primary care leaders to play a more active role in ICSs. PCNs are formed of multiple organisations coalescing around common goals with varying degrees of infrastructure for doing so. There is clear commitment to primary care at scale and a recognition of the important role that primary care can have at different levels. PCNs will be a key partner in improving population health and building neighbourhood resilience, including driving integration at neighbourhood or district level (as set out in [Claire Fuller's stocktake](#)).

### Case study – How a primary care provider collaborative can improve primary care representation, subsidiarity and sustainability

In Derbyshire, the recently developed GP Provider Board (GPPB) acts as a provider collaborative, growing from humble beginnings as a group of GPs meeting to becoming a single, unified, mandated representative of general practice to the ICS. The collaborative brought together all the PCNs in Derby and Derbyshire via their clinical directors, and individual practices via their elected local medical committee, and secured recurrent ICB funding in 2023 to represent general practice. This approach has helped to create a mechanism for future subsidiarity and is harnessing system-level general practice expertise to improve

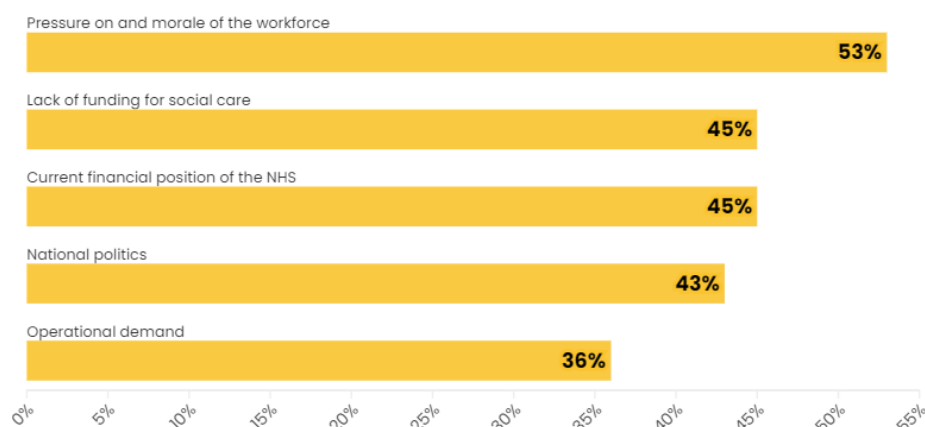
long-term sustainability, improve patient outcomes and reduce health inequalities.

The GPPB has representation at all the key system meetings, notably the Provider Collaborative Leadership Board and Integrated Place Executive, as well as the various delivery boards. The board works closely with the ICB primary care team led by ICB's director of primary care, adding value to their work, exploring system opportunities and more broadly increasing the understanding, visibility and support for general practice and PCNs.

# Barriers to progress

## Barriers to integrated working

**Top five answers for: "What do you think will be the biggest barriers to integrated working within your system over the coming 24 months?"**



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
Up to three options permitted to be selected from choice of 10, n=47

ICS leaders identified a number of barriers that are impeding their progress and which require action from government and national bodies. The top three identified in our survey are consistent with last year’s findings: pressure on and morale of the workforce, the lack of funding for social care, and the current financial position of the NHS. We discuss national politics as a barrier to integration in section 6.

## Workforce

ICS leaders are thinking ambitiously about how to support the workforce, taking a whole-system approach and considering the interplay between health and social care. However, the workforce challenges faced by ICSs are severe. As of December 2022, vacancies in the NHS reached 124,000, which represents 8.9 per cent of planned FTE workforce levels, and vacancies in social care

have risen to 165,000. The UK has on average fewer doctors and nurses per person compared to peer countries. ICS leaders have welcomed NHSE's recently published NHS Long Term Workforce Plan, which is a welcome step to tackle persistent workforce shortages in the healthcare sector, although leaders have also highlighted their concern that there remains a lack of a comparable plan for social care. The plan sets an ambitious 2.2 per cent productivity target, but there is a risk that this could set systems up to fail against their financial targets in future years.

## Social care

ICS leaders are concerned about the impact of longstanding underinvestment in the social care sector, despite recent extra funding in the 2022 Autumn Statement. Staff vacancies in the sector have risen to 165,000 and low wages associated with lack of opportunities for progression make it difficult for social care to compete with other sectors for staff, as noted by one ICP chair:

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“Money goes to the NHS for a pay rise, it doesn't include people doing very similar jobs in social care. So all that's happened is people are being sucked out of social care and into the NHS because they're being better paid there. Even though they're in one system.”

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The recently announced £600 million to support the social care workforce over the next two years will help bridge some of those gaps in the social care workforce, but there is still a desperate need for a long-term social care workforce plan.

Local government leaders also highlighted how pressure over the winter, including difficulties in discharging hospital patients due in part to a lack of capacity in social care, have created tensions between NHS and local government partners.



## Recommendation

We welcome the NHS Long Term Workforce Plan but call on the government to develop an equivalent plan for the social care workforce to recognise the contribution and value of this sector.

## NHS financial position

Some ICS leaders described how financial constraints have tested relationships within their systems, particularly in the context of competing priorities. One ICB CEO stated that their ‘financial position is putting a lot of strain on partnerships with local authorities’. Financial challenges exist in both the NHS and local government. Another ICB CEO reflected that ‘all-consuming’ financial issues in one of their local authorities had created a ‘retrenching back to people’s organisations’.

The discrepancy between how funding is allocated and distributed between NHS and local authority partners can act as a barrier to a truly integrated way of working. Local government leaders indicated that one-year settlements and the pressure of balancing the books at the end of the financial year can make it challenging to work collaboratively on long-term aims. One local government leader described the challenge of annual settlements creating ‘feast and famine collaboration’. Our research supports the Hewitt review’s recommendation for multi-year funding settlements, which would give partners more bandwidth to plan together in the medium-to-longer term.

Capital spending remains a particular concern of ICS leaders, and will be essential if the sector’s productivity targets are expected to be met. Capital spend has declined in real terms throughout the 2010s and lags behind other OECD countries. Increased

investment in this area, such as upgrading estates and IT equipment, can enable better productivity, but ICS leaders highlight the impact that uncertainty and delays on the allocation of capital funding can have on the system's capabilities to deliver high-quality care.

One ICB CEO described the consequences of constantly moving the goal posts on capital funding:

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“There needs to be a different way for capital to be identified and then secured, because otherwise it's just a waste of everybody's time. We raise people's expectations and then have to manage the political fallout.”

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Our research further supports Patricia Hewitt's recommendation of a cross-government review of the entire NHS capital regime.

Many members have faced challenges associated with complex capital allocation processes. For example, Bedfordshire, Luton and Milton Keynes ICS met difficulties when bidding for community diagnostic centres to support capacity in ophthalmology. Although CDC guidance supported ophthalmology as an appropriate pathway for inclusion, the system was later advised that ophthalmology was no longer being supported with capital or revenue funds, after spending significant time building a case with system partners. This significantly delayed the programme and created tensions between national guidance and the ICS priority to address health inequalities. Ophthalmology was eventually supported following significant intervention from CEOs and remodelling of the plans.

## Recommendation

We support the government's commitment to reviewing the entire NHS capital regime in response to the Hewitt review. We call on the government to include in this review the amount of capital funding as well as the complex allocation process.

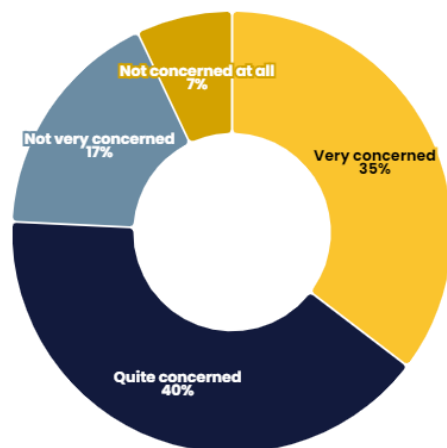
## Capacity to deliver service transformation

As ICBs take on new commissioning functions for primary pharmacy, optometry and dentistry services and are also now responsible for implementing large elements of the NHS Long Term Workforce Plan, there is a danger they are being asked to take on too much while simultaneously reducing their running costs.

In March 2023, [NHSE](#) announced that ICBs should plan for a 30 per cent nominal terms reduction of their running costs by 2025/26, with no inflationary uplift, which could be closer to a 40 per cent reduction in real terms. Three out of four ICB leaders are concerned that this reduction in their running cost allowance (RCA) will impede their system's ability to deliver the ambitions of their strategy.

**"How concerned are you, if at all, that the recently announced ICB running cost reductions will impede your ICS's ability to deliver the ambitions set out in your integrated care strategy?"**

Very concerned Quite concerned Not very concerned Not concerned at all



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
n=40

One ICB CEO cited running cost allowances as the top barrier to integrated working over the next two years, which they felt is ‘getting in the way of the work.’ Another described feeling that they are facing ‘war on multiple fronts’, from inheriting massive legacy issues, to a national NHS budget crisis, a challenging winter and now ‘making major cuts in the ICB workforce’ (after they had been told no jobs would go).

## New commissioning functions

ICBs have recently taken on new functions, including the commissioning of primary pharmacy, optometry and dentistry (POD) services. Most leaders surveyed felt very or moderately well prepared to take on each of these additional functions: nine out of ten ICB leaders felt prepared for pharmacy and optometry services and seven out of ten for dentistry.

However, these new functions will require specialist capacity, which risk being depleted by the RCA reductions. ICS leaders highlighted concerns regarding this transition, including the lack of appropriate and high-quality data for many of the services, a

lack of visibility on the risk they are taking on and significant challenges in dentistry linked to the national dental contract. One ICB chair wanted to take on POD functions but felt they were 'being rushed through as our budgets are reducing, which will limit our ability to change services for the better.'

Another described the challenges posed by cuts to their management costs to taking on new services which have legacy issues:

"We are inheriting services with significant operational and financial challenges, especially dentistry. The transferring infrastructure - particularly workforce - is small and will be included in the RCA process and so will likely be further diminished." These findings reflect the experience of early adopter systems.

## Recommendation

NHSE should work closely with ICBs to ensure that they have access to the data and the capacity they need to effectively discharge their new commissioning functions.



improvements in population health and reduce health inequalities. This demonstrates a significant change in mindset among healthcare leaders away from a more medicalised NHS focus.

## Case study: Creating a smoke-free South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)

Within South Yorkshire and Bassetlaw (SYB) nearly 200,000 people smoke, of which more than half will die prematurely (losing on average ten years of life) from smoking-related illnesses. In order to support people to stop smoking, SYB ICS launched the QUIT programme in partnership with Yorkshire Cancer Research, five local authorities and local stop smoking services. The programme aims to save lives, reduce health inequalities and reduce hospital readmissions by making effective treatment for tobacco addiction part of the routine care offered in hospitals. [Find out more.](#)

ICS leaders recognise the importance of addressing both immediate operational pressures such as improving access and reducing waiting times, and longer-term priorities such as achieving the three big shifts towards preventing ill health, personalised care and participation, and from a predominant model of hospital care to care closer to home. However, a key theme across our research was a feeling that these more transformational priorities are often crowded out by a focus nationally on what one ICB CEO termed ‘a small number of NHS driven, short-term political priorities - money, waiting lists, ambulances etc.’ One joint ICB/ICP chair described how the focus on urgent ‘here and now’ issues across yearly financial settlements limits progress on the prevention agenda:

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“What you can’t do is just hope it works – the urgent trumps the important.”

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One ICB CEO was concerned that this mismatch could damage local relationships: “Other partners on the board might start to say ‘I’m not in this to talk constantly about ambulance handover times.’” This sentiment was echoed by the system partners we spoke to. Primary care and place leaders spoke in depth about how tensions between local and national priorities limited their ability to focus on prevention work. The County Council Network’s report on the role of county authorities in ICSs similarly found that a focus on NHS priorities such as discharge and a command-and-control culture, was impeding collaboration.

In a taxpayer-funded system in which politicians are accountable for service performance and delivery, ministers will naturally expect to set national priorities for ICSs. But as some recent examples indicate, there is a risk that NHS priorities become more focused on short-term political imperatives in the run up to a general election. Our survey demonstrates concern among ICS leaders that national politics could become a barrier to integrated working over the next two years (See chart 6). A joint ICB/ICP chair described the pull between local and national priorities as feeling like an elastic band: “One minute we are independent and the next thing we ping back.” However, they recognised the role played by NHSE in acting as a political buffer for the system: “NHSE does well under extraordinary pressure from politicians in a way the NHS never has been before.”

## Recommendation

As the Hewitt review and the Health and Social Care Select Committee proposed, DHSC and NHSE should focus on setting a small number of targets based on outcomes and give ICSs the freedom to innovate in how they deliver against these.

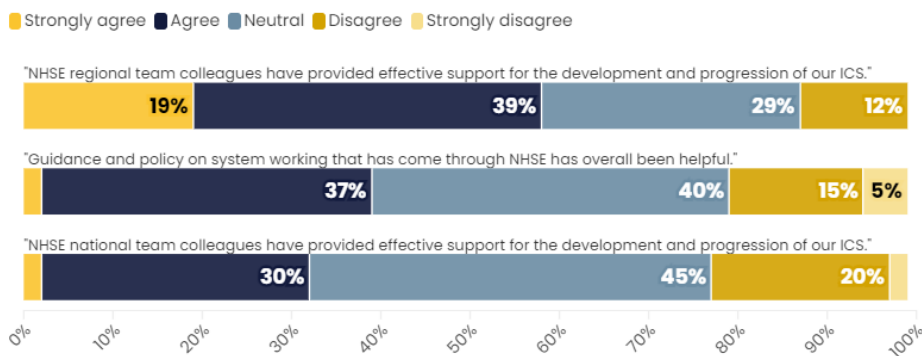


# ICSs and the role of the centre

## Support for ICS development

ICB leaders are generally positive about the support they receive from their NHSE regional team, with almost 60 per cent agreeing regional colleagues’ support has been effective for the development and progression of their ICS. One joint ICB/ICP chair said they felt lucky to have their regional director, who fosters good working relationships with all ICSs in the region and provides ‘a very good filter from the top’.

### "To what extent do you agree or disagree with the following statements on NHS England support?"



Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23  
 For the first question n= 41, for the second and third questions n=40

When it comes to support they receive from NHSE’s national team, and on national guidance and policy on system working, ICB leaders want to see more co-production to ensure that national support and guidance is aligned with ICS development needs and believe the ICS Network can play a valuable role in facilitating this. The shift to ICSs will demand a different approach and ways of working, with a greater focus on sector-led improvement (for example through peer review) and ICS leaders more directly involved in the development of healthcare policy, which was highlighted by the Hewitt review. The approach taken by NHSE to developing the most recent operational planning guidance, supported by Patricia Hewitt and others, marked a new

approach to co-development which resulted in a document with fewer priorities overall and greater scope for longer-term priorities.

## Recommendation

Through their response to the Hewitt review and new operating framework, DHSC and NHSE have committed to embedding a co-production approach. Co-production of policy and guidance impacting ICSs should become the norm.

## Accountability arrangements

ICS leaders acknowledged the pressure NHSE is under in recovering the health and care system, managing operational demand and managing its own internal transformation programme. ICS leaders are supportive of the intentions set out through NHSE's new operating framework and there has been positive feedback on more recent changes, such as the approach to this year's planning guidance. However, the pace at which NHSE is embedding the new framework was highlighted as a challenge by ICS leaders in our research.

Many of the ICB leaders we spoke to recognised the issue of repeat and sometimes conflicting data requests and there was strong support for Patricia Hewitt's recommendations aimed at rationalising the number of central requests. A joint ICB/ICP chair reflected: "I think NHSE is trying hard to be more supportive and collaborative. However, there are still too many last-minute requests for data and too much unnecessary bureaucracy."

There was recognition through our research that the system will continue to evolve. One ICB CEO described a future in which further devolution to ICSs could in the long-term call into question the role of NHSE's regional teams:

“If in my ICS I can create a truly integrated care model that on the day-to-day basis is run by our providers through collaboratives and places, this will allow the ICB to take on the significantly needed strategic commissioning and oversight duties and I think there’s a really legitimate question about why you need ICBs as well as NHSE regionally. But we’re about two or three years away from that conversation because we need to develop our places.”

There will, however, be differences of approach based on local context. For example, the regional office may have a greater role in regions such as the south west and the midlands where there are many small ICSs.

ICS leaders also described work they had delivered in partnership with their NHSE regional teams to clarify accountabilities locally. One ICB CEO felt that having the regional NHSE locality performance lead embedded within the ICB was helpful, although they felt it was still quite a ‘crowded pitch’ that can lead to ‘trusts feeling pulled in many directions, distracting them from the actual work.’ An acute trust leader made the point that further devolution cannot take place without first clarifying accountabilities, which was reinforced through the recent NHS Providers survey on regulation. Future developments in this area should be co-produced with ICS leaders and other system partners to ensure clarity about roles and responsibilities.

## Adopting a long-term approach

The NHS Confederation, other health and care membership bodies and think tanks have been clear that, while ICSs are well-placed to deliver long-term improvements to population health, they will take time to embed and will require long-term political commitment to realise their full benefits. A joint ICB/ICP chair we spoke to asked for an ‘understanding that the things we’re being asked to do are long-term – we won’t change life expectancy in

two or five years, but we might have a fighting chance in ten years or 15 years.’

Analysis of similar integration reforms internationally demonstrates that culture and behaviour take time to catch up with major legislative or policy reforms. While some ICSs have been operating for several years before the Health and Care Act, others have not benefitted from a history of collaboration between NHS, local government and other partners. ICS leaders are clear that they believe integration is the only way to achieve improvements in population health outcomes and improve system performance. As one ICB chair commented:

“The NHS has been through so many changes, however it will take time for everyone to realise that this latest change is going to be permanent and will not be reversed by the next minister or government. If this were to happen, the NHS would, in my view, be irreparable.”

It will be important that current and future governments recognise the international evidence that integration reforms take time to improve population health outcomes, and continue to make a long-term commitment to ICSs, allowing them to deliver local reform to services.

# Summary of recommendations

On behalf of ICS leaders, we make the following recommendations:

## **Social care workforce plan**

We welcome the NHS Long Term Workforce plan but call on the government to develop an equivalent plan for the social care workforce to recognise the contribution and value of this sector.

## **Capital spending review**

We support the government's commitment to reviewing the entire NHS capital regime in response to the Hewitt review. We call on the government to include in this review the amount of capital funding as well as the complex allocation process.

## **Support for new commissioning functions**

NHSE should work closely with ICBs to ensure that they have access to the data and the capacity they need to effectively discharge their new commissioning functions.

## **Devolve to evolve**

As the Hewitt review and the Health and Social Care Select Committee proposed, DHSC and NHSE should focus on setting a small number of targets based on outcomes and give ICSs the freedom to innovate in how they deliver against these.

## **Co-production**

Through their response to the Hewitt review and new operating framework, DHSC and NHSE have committed to embedding a co-production approach. Co-production of policy and guidance impacting ICSs should become the norm. This should include, in particular, work on system accountability arrangements.

## Annex 1 - explanation of analysis conducted in association with Carnall Farrar

Carnall Farrar's insight and collaboration engine combines an automated data pipeline using national data, the benchmarking of a suite of metrics against demographic place and ICS peers, and the setting and evaluation of strategic goals for improving population health and reducing health inequalities.

Population health performance is measured using a basket of 13 different measures, including sufficient GP support; mental health care programmes; bowel cancer screening; breast cancer screening; A&E cancer rates; crisis plans; diabetes foot amputation; diabetes management; NHS health checks; pressure ulcers in A&E; smoker support; statin prescription; and the cancer care survey.

Carnall Farrar standardised each of these 13 metrics into one score, on a scale of 1 to -1, to enable comparisons across different scales. The values were then averaged out and normalised using a z-score. Thus, a value of 0.5 represents 0.5 standard deviations higher than the mean, while a lower score would represent a lower population health management score in relation to others based on Carnall Farrar's chosen metrics.

An unweighted average of two questions on place-based partnerships was used as a measure of the most 'place-enthusiastic' places:

- 'To what extent do you agree or disagree that place-based partnerships have the requisite level of resourcing and maturity to deliver the ambitions outlined in your integrated care strategy?' (On average, ICSs averaged a 2.1, with 2 being agree, and 3 being neutral)
- 'How clearly, if at all, do you feel governance mechanisms and accountabilities are defined within place-based partnerships?'

(On average, ICSs averaged a 2.71, with a 2 being clear, and a 1 being very clear).

## Annex 2 – The Hewitt review priorities for ICS leaders

Since publication of the Hewitt review, the NHS Confederation's ICS Network has been working with ICS leaders to define the priority areas that ICS leaders think will have the biggest impact on their future success. Leaders of ICBs and ICPs have consistently told us that delivering prevention is their key priority. The priority recommendations that have emerged are those that advance that goal:

Priority short-term recommendations:

1. **Defining prevention** – ICS leaders see the shift towards preventative services and interventions as fundamental to ICSs' mission and developing a clear definition of preventative services will provide the foundation for ambitious change and help to understand best practice.
2. **Fewer national targets** – A smaller number of national targets, which allow equal weight for local priorities, is fundamental to devolution to system and place level, empowering local leaders to lead and shift resources to prevention.
3. **Allocations and payment mechanism flexibility** – Rolling a greater share of ICS funding into ICBs' overall allocations, rather than the 'drip drip' of smaller funding pots that come with additional reporting requirements, and an immediate change in NHS Payment Scheme guidance to allow flexibility for intra-system payments, are crucial to increasing efficiency and achieving a shift to prevention.
4. **Regulation** – The review proposes a new role for the CQC in relation to systems which will take time to get right. It also proposes new High Accountability and Responsibility

Partnerships (HARPs), which would allow the most mature ICSs greater freedoms.

5. **ICBs' Running Cost Allowance (RCA) reduction** – Scaling back the RCA reduction to only 20 per cent, rather than 30 per cent, before Budget 2024 would allow systems to focus on access and productivity, rather than organisational restructuring.

Priority longer-term recommendations:

1. **Capital** – Lack of readily available capital is a drag on the transformation needed to improve services and productivity. A rapid review of the capital sign-off process will help make sure that existing budgets are reaching projects quickly and best used to meet local needs.
2. **New NHS payment mechanism** – While allowing greater flexibility on intra-system payment mechanisms will help in the short-term, in the longer-term ICS leaders welcome the proposal to create a bespoke payment mechanism, learning from best practice internationally.
3. **Social care** – ICS leaders report that integration will be hindered by lack of capacity across the social care sector including for younger adults, not just older people. A strategy for the social care workforce, complementary to the NHS workforce plan, is needed.

Following the government's joint response to the review and Health and Social Care Select Committee inquiry, the ICS Network is working with key partners to take forward a collaborative approach to implementation of the review, which will focus on these eight priority areas.





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